COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

CHART Phase 2: Implementation Plan Lawrence General Hospital

HPC approval date: September 18, 2015

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Version: 3

Introduction

This Implementation Plan details the scope and budget for Lawrence General Hospital's ("Contractor") Award in Phase 2 of the Health Policy Commission's (HPC) Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program. The Implementation Plan is incorporated by reference into and is subject to the requirements of the Phase 2 Award Contract, including the Phase 2 Terms & Conditions.

Many capitalized terms appearing in the Implementation Plan are defined in the Phase 2 Terms & Conditions or the Phase 2 Request for Proposals (RFP). In addition to capitalized terms, the Implementation Plan may include other acronyms and/or abbreviations whose meaning is understood by Contractor and the HPC in the context of the Implementation Plan. If there is disagreement concerning the meaning of a term, acronym, or abbreviation, the HPC's interpretation shall govern.

Contents of the Implementation Plan

- Key Personnel
- Target Population(s)
- Aim Statement(s)
- Baseline Performance
- Estimated Monthly Impact
- Driver Diagram
- Service Model
- Service Worksheet
- Service Mix
- List of Service Providers/Community Agencies
- Summary of Services
- Measurement Plan:
  - Cohort-Wide Standard Measures
  - Program-Specific Measures
- Continuous Improvement Plan
- Enabling Technologies Plan
- Other Essential Investments
- Key Dates
- Community Partners/Subcontractors
- Deliverables and Reporting
- Payment Plan
- Budget

Key personnel

Name	Title	CHART Phase 2 Role
Dianne Anderson, RN, MSN	President and Chief Executive Officer	Executive Sponsor
Robin Hynds, MSN, RN, CPHM	Vice President of Care Continuum	Co-Clinical Investment Director
Nicole Garabedian, MSN	Director of Integrated Care	Co-Clinical Investment Director and Project Manager
Deborah Wilson	Chief Financial Officer	Operational Investment Director
Greg Parsons	Director of Finance Operations and Controller	Financial Designee

Target population

Definition*

Patients as identified either:

- By an initial biopsychosocial risk assessment scorecard
  - Medium risk: 2-4 risk factors,
  - High risk: 5 or more risk factors,
- A 30-day readmission to the hospital**

Quantification

- ~2,424 patients (October 2015 data of 202 unique patients)

*Inclusive of patients who are >/= 18 year of age in an inpatient or observation status, who were discharged from the hospital or transferred to another acute care facility or post-acute facility and exclusive of OB diagnosis, expired, and waiver.

**Thirty day readmission is defined by a patient who has had a readmission from the index admission within the prior 30 days.

Aim Statement(s)

Primary Aim Statement
Reduce 30-day readmissions by 20% for patients identified by either biopsychosocial risk assessment or recent 30-day readmission by the end of the 24 month Measurement Period.

Secondary Aim Statement*
Reduce 30-day ED returns by 20% for patients identified by either biopsychosocial risk assessment or recent 30-day readmission by the end of the 24 month Measurement Period.

*Your secondary aim statement is a performance measure only and is not tied to Achievement Payment.

Baseline performance – Readmission reduction*

		Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Total
Hospital-Wide	Readmits	84	77	73	95	80	81	81	72	67	67	74	69	827
	Discharges	866	799	947	871	925	882	936	890	847	870	851	874	10,236
	Rate (%)	9.7%	9.6%	7.7%	10.9%	8.6%	9.2%	8.7%	8.1%	7.9%	7.7%	8.7%	7.9%	8.1%
Target Pop	Readmits	33	31	36	41	32	43	26	21	25	30	33	37	358
	Discharges	269	250	293	276	293	284	280	238	236	253	244	249	3038
	Rate (%)	12.3%	12.4%	12.3%	14.9%	10.9%	15.1%	9.3%	8.8%	10.6%	11.9%	13.5%	14.9%	11.8%

*This data reflects previous version of baseline performance; updated performance data was submitted as part of required periodic reporting.

Estimated monthly impact

	Current Expected Served	Current Expected Events	New Expected Avoided Events	New Expected Events
Reduce target population 30-day readmissions	We will offer this target population enrollment into the transitional care program. Estimated number is 2,424 per year (202 per month).	Given an average readmission rate of 11.8% for the population we expect 286 readmissions per year (est. 24 per month).	Given a goal of 20% reduction in readmissions we expect to avoid 114 readmissions over 2 years.	We expect 19 readmissions per month over 2 years for this target population.

Driver Diagram

Abridged Impl … r contracting purposes

Reduce 30-day readmissions by 20% for patients identified by either biopsychosocial risk assessment or recent 30-day readmission by the end of the 24 month Measurement Period.

Utilize evidence-based transitional care best practices

- Develop evidence-based transitional care maps to ensure best practices
- Provide disease-specific, evidence-based care delivery protocols at both the inpatient and outpatient level

Design reliable care management workflows

- Ensure continued care management for 90 days post-discharge
  - High-touch, social work based model with regular communication and patient coaching
  - Nursing interventions for patients with comorbid medical needs
- Develop workflows that support cross continuum care planning
  - Process of communication, content of handoff, and follow-up care plan post-psych hospitalization with Lahey Health Behavioral Services as needed
  - Algorithm to identify patients who would benefit from transitional care from Elder Services
  - Feedback loops for alerts sent to Care at Hand with Elder Services
- Develop a reliable, consistent process to communicate care plans with community providers
- Provide community care team members with crisis reduction real-time interventions for behavioral health patients

Engage Community Partners

- Leverage community resources for behavioral health and substance abuse
  - Partner with Lahey Health Behavioral Services for crisis interventions
  - Contract Elder Services for community based care transitions
  - Collaborate with Home Health VNA for home complex care plans
- Connect patients with in-home disease screenings through the Elder Services to prevent unnecessary hospital admissions

Optimize technology and tools

- Connect and interface with the MassHIway to transmit CCDs and notifications to Elder Services
- Develop Morrisey as a documentation platform for cross-continuum care planning, risk-stratification and sending alerts
- Customize Care at Hand to receive community documentation, in-home risk-stratification and receipt of alerts
- Offer PatientLink to encourage patient activation and engagement in their care through access to their own secure, personal health record

Lawrence General Hospital – Version 3

Service model

Narrative description

The Transitional Care Program team will utilize the following strategies to engage patients, families, and caregivers:

- Education, information and communication to patients, families, caregivers, providers and key stakeholders about the program and its benefits to helping improve population health.
- Use of strategies such as motivational interviewing in order to work individually with patients on what their personal goals of care are and helping them to set those that are meaningful and attainable to them.
- Working and strategizing with community leaders and organizations to understand the health needs within each diverse area of the Merrimack Valley and collaborate on innovative programming designed to impact those needs.
- Ensure communication about the individual needs of a high risk patient is accessible to all caregivers involved so that to the end user it's viewed as seamless and coordinated.
- Provide navigational assistance of the health care system to those patients requiring help and advocacy to minimize convoluted fragmentation.
- Ensure staffing complement addresses and meets the diversity and culture needs of those utilizing the program (i.e. bilingual staff etc.).

Services to be delivered include: longitudinal, interdisciplinary, evidence-based medical and social care; follow-up phone assessments designed to evaluate symptoms and compliance with the discharge plan; patient education and teaching that is culturally relevant to empower targeted patients to better manage their care; coordination of a variety of community-based social support services including prescription assistance, transportation, mental health counseling, etc.; and seamless communication related to patient status and intended care plan to all of the patient's providers across the continuum starting in the inpatient arena and moving towards the outpatient.

Case finding will be accomplished as soon as a patient enters the hospital setting either through the Emergency Center, Surgical area and/or direct admission. An assessment to identify at risk patients will be accomplished by the nurse Case Management staff and a work list for all Social Workers will be created. The SW staff will then meet patient, assign acuity/risk level and set appropriate interventions based on needs identified through motivational interviewing. The highest risk patients will be assigned a transition coach in the home through a subcontracting relationship with Elder Services of the Merrimack Valley (ESMV). SW staff will continue to follow all enrolled patients for 90 days post discharge ensuring connection with available resources and addressing social determinants of health that lead to over utilization and readmissions. A hospital based community resource worker will assist SW staff on appropriate resource allocation. A Clinical Nurse Leader will address medically complex issues for patients with chronic disease management needs and/or new diagnoses. The CNL will also work closely with local rehabilitation centers like skilled nursing facilities to manage transitional needs and keep patients at the appropriate level of care setting. Additional involvement of community based organizations such as Home Health Visiting Nurse Association and Lahey Behavioral Health will help adjunct care.

Service worksheet

Service Delivered

- × Care transition coaching
- × Case finding
- × Behavioral health counseling
- × Engagement
- × Follow up
- × Transportation (set up)
- × Meals (set up)
- × In home supports (ESMV)
- × Home safety evaluation (ESMV & HHVNA)
- × Logistical needs
- × Whole person needs assessment
- × Medication review, reconciliation, & delivery (as needed)
- × Education
- × Advocacy
- × Navigating
- × Crisis intervention
- × Motivational interviewing
- × Linkage to community services
- × Physician follow up
- × Housing connections
- × Adult Day Health (as needed)
- × Detox (as needed)

Personnel Type

- × Hospital-based nurse (CNL)
- × Hospital-based social worker
- × Hospital-based pharmacist (as needed- in kind)
- × Hospital based community resource specialist
- × Community-based nurse (subcontracted through ESMV)
- × Community-based social worker (subcontracted through ESMV)
- × Community-based behavioral health worker (LBH as needed)
- × Community-based psychiatrist/ mental health clinician (as needed)
- × Community-based transition coach (subcontracted through ESMV)
- × Home health agency (as needed)
- × Skilled nursing facility (as needed)
- × Hospital and Community Based Palliative Care
- × Community-based pharmacist(connection as needed)

Service Availability

- × Mon. – Fri.
- × Weekends (ESMV available for in house evaluation- SW on call
- × Holidays (SW on call)
- × Days

Service mix

Service	By Whom	How Often	For How Long
Post-discharge transition coaching	ESMV CCTP Coaches	2 FTE (Transition Coach); Per Diem for additional needs. 1.5 CHART funded, 0.5 ESMV funded through United Health Care.	30-90 days
Social Work Management for Hospitalized Patients including transitional support post- discharge	LGH	2 FTE (Social Worker – MSW)	During hospital stay and 90 days post discharge
Nursing Management for Hospitalized Patients including transitional nursing support post- discharge	LGH	1 FTE (RN Care Manager)	During hospital stay and 90 days post discharge
Transitional Support	LGH	1 FTE (Transitional Support)	During hospital stay and 90 days post-discharge
Clinical Pharmacist	LGH	.25 FTE	During hospital stay as needed

# FTE/units of service hired at my organization	**4.25**
# FTE/units of service contracted	**2**

List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Behavioral Health Crisis Services	Lahey Behavioral Health	Existing relationship
Elder Services/ Transition Coaching	Elder Services of the Merrimack Valley	Existing relationship, but will be expanding scope
Home Health Care	Home Health Visiting Nurses Association, Merrimack Valley	Existing relationship

Summary of services

Clinical service and staffing mix

Prior to Presentation:
- Care Management platform is programmed with assessment questions to identify patients who are at a medium and high risk of readmission

Upon presentation to ED, Surgical Center or Direct Admit:
- An assessment to identify at risk patients will be accomplished by the nurse Case Management staff ; patients will be automatically triaged to a work list for further assessment by a social worker for medium and high risk in Morrissey
- A work list for all Social Workers will be created of patients identified as medium or high risk for readmission
- (Patients who are 30-day readmit or prior CHART patients returning <90s will be auto-populated on list; manual entry available)
- The SW staff will then meet patient, assign acuity/risk level and set appropriate interventions based on needs identified through motivational interviewing
- If a readmission, Morrissey will prompt a “readmission interview”
- A Clinical Nurse Leader will address medically complex issues for patients with chronic disease management needs and/or new diagnoses and perform readmission interview
- A hospital based community resource worker will assist SW/RN staff to refer and coordinate follow up service

After Discharge:
- The medium and highest risk patients will be assigned a transition coach by Elder Services of the Merrimack Valley (ESMV). .
- The CNL will work closely with local rehabilitation centers like skilled nursing facilities to manage transitional needs and keep patients at the appropriate level of care setting.
- SW staff will continue to follow all enrolled patients for 90 days post discharge ensuring connection with available resources and addressing social determinants of health that lead to over utilization and readmissions

Cohort-wide standard measures – Hospital utilization measures

Data elements	All	Target Population
1. Total Discharges from Inpatient Status (“IN”)	x	x
2. Total Discharges from Observation Status (“OBS”)	x	x
3. SUM: Total Discharges from IN or OBS (“ANY BED”)	x	x
4. Total Number of Unique Patients Discharged from “IN”	x	x
5. Total Number of Unique Patients Discharged from “OBS”	x	x
6. Total Number of Unique Patients Discharged from “ANY BED”	x	x
7. Total number of 30-day Readmissions (“IN” to “IN”)	x	x
8. Total number of 30-day Returns (“ANY BED” to “ANY BED”)	x	x
9. Total number of 30-day Returns to ED from “ANY BED”	x	x
10. Readmission rate ("IN readmissions" divided by "IN")	x	x
11. Return rate (ANY 30-day Returns divided by “ANY BED”)	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – ED utilization measures

Data Elements	All	Target Population
12. Total number of ED visits	x	x
13. Total number of unique ED patients	x	x
14. Total number of ED visits, primary BH diagnosis	x	x
15. Total number of unique patients with primary BH diagnosis	x	x
16. Total number of ED visits, *any* BH diagnosis	x	x
17. Total number of unique patients with any BH diagnosis	x	x
18. Total number of 30-day ED revisits (ED to ED)	x	x
19. Total number of 30-day revisits (ED to ED), primary BH diagnosis	x	x
20. Total number of 30-day revisits (ED to ED), any BH diagnosis	x	x
21. ED revisit rate	x	x
22. ED BH revisit rate (primary BH diagnosis only)	x	x
23. ED BH revisit rate (any BH diagnosis)	x	x
24a. Median ED LOS (time from arrival to departure, in minutes)		
24b. Min ED LOS (time from arrival to departure, in minutes)		
24c. Max ED LOS (time from arrival to departure, in minutes)		
25a.Median ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
25b. Min ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
25c. Max ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
26a. Median ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)		
26b. Min ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)		
26c. Max ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)		

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Service delivery measures

Data elements	Target Population
27. Total number of unique patients in the target population	x
28. Number of acute encounters for target population patients	x
29. For acute encounters in measure #28, number of these with any CHART service provided after discharge and within 48 hours	x
30. Total number of contacts for the target population	x
31. Average number of contacts per patient served	x
32a. Min number of contacts for patients served	x
32b. Max number of contacts for patients served	x
33. Number of units of service provided by service modality (including, e.g., phone call, virtual interaction, face to face in office, face to face in home, etc.)	x
34. Number of units of service provided, by service types (e.g., care coordination, medication optimization, clinical care, counseling, needs assessment, etc.)	x
35. Number of units of service provided, by role type (NP, LICSW, Pharmacist, Community Health Worker, Peer)	x
36. Average time (days, months) enrolled in CHART program per patient	x
37. Range time (days, months) enrolled in CHART program per patient	x
38. Proportion of target population patients with care plan	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Payer mix

Data elements	Medicare	Medicaid	Commercial
39. Count of patients in the Target Population	x	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Program-specific measures (1 of 2)

Measure Definition	Numerator	Denominator	Based on your enabling technology decision, how will you collect this information?
COPD 30-day all-cause readmission for target and enrolled population*	All CHART patients with a 30-day readmission with the principle index diagnosis of COPD	All patients enrolled in CHART Program with select principle diagnosis	MCCM and Paragon
Diabetes 30-day all-cause readmission for target and enrolled population*	All CHART patients with a 30-day readmission with the principle index diagnosis of Diabetes	All patients enrolled in CHART Program with select principle diagnosis	MCCM and Paragon
Congestive Heart Failure 30-day all-cause readmission for target and enrolled population*	All CHART patients with a 30-day readmission with the principle index diagnosis of CHF	All patients enrolled in CHART Program with select principle diagnosis	MCCM and Paragon
Pneumonia 30-day all-cause readmission for target and enrolled population*	All CHART patients with a 30-day readmission with the principle index diagnosis of PNA	All patients enrolled in CHART Program with select principle diagnosis	MCCM and Paragon
AMI 30-day all-cause readmission for target and enrolled population*	All CHART patients with a 30-day readmission with the principle index diagnosis of AMI	All patients enrolled in CHART Program with select principle diagnosis	MCCM and Paragon
Identify # and % of patients in the enrolled population that had a clinical care summary document (CCD) provided.	Number of CCD documents transmitted	All patients enrolled in CHART Program	MCCM and Paragon
Identify # and % of patients in the enrolled population that had a clinical care summary document (CCD) provided to Elder Services	Number of CCD documents transmitted to Elder Services	All patient enrolled in CHART Program receiving care from Elder Services	MCCM and Paragon
Referrals/consults for behavioral health/ psychiatric treatment	Number of referrals/consults for behavioral health/psychiatrics treatment	All patients enrolled in CHART Program	MCCM
Referrals to cardiac rehabilitation	Number of referrals to cardiac rehabilitation	All patients enrolled in CHART Program	MCCM
Referrals to diabetes educator	Number of referrals to diabetes educator	All patients enrolled in CHART Program	MCCM

Program-specific measures (2 of 2)

Measure Definition	Numerator	Denominator	Based on your enabling technology decision, how will you collect this information?
Referrals/consults for Palliative Care	Number of referrals consults for Palliative Care	All patients enrolled in CHART Program	MCCM
Referrals to community health and wellness programs	Number of referrals to community health and wellness programs	All patients enrolled in CHART Program	MCCM
Other referrals to outpatient services	Number of referrals to other outpatient services	All patients enrolled in CHART Program	MCCM
Telephonic touch-points (i.e. post-discharge phone calls, appointment reminders, etc.)	Number of telephonic touch-points (i.e. post-discharge phone calls, appointment reminders, etc.)	All patients enrolled in CHART Program	MCCM
Warm-Hand offs	Number of warm-hand offs	All patients enrolled in CHART Program	MCCM
Attendance at interdisciplinary or interagency care planning meetings	Attendance at interdisciplinary or interagency care planning meetings	All patients enrolled in CHART Program	MCCM
Appointment scheduling	Number of appointments scheduled	All patients enrolled in CHART Program	MCCM
Obtaining a PCP for patients with no PCP	Number of PCPs obtained	All patients enrolled in CHART Program	MCCM
Provision of assistance with transportation	Number of times provision or assistance with transportation occurred	All patients enrolled in CHART Program	MCCM
Provision of assistance with housing	Number of times provision of assistance with housing occurred	All patients enrolled in CHART Program	MCCM
Provision of assistance with food and nutrition counseling	Number of provisions of assistance with food and nutrition counseling.	All patients enrolled in CHART Program	MCCM

Continuous improvement plan (1 of 2)

1. How will the team share data?	• The Transformation Analytics Group (TAG) meets twice monthly to review data and oversee progress towards goals related to data capture and reporting. This group includes executives that are members of the Transformation Steering Committee and CHART leadership and operational (CHART) group members. • The CHART leadership and operational group meets at least monthly to review the programs activities and progress towards the program goals. Community partners are included in this group. • A subset of the CHART leadership and operational group meets on a more frequent basis with the CHART day to day operations team. • The Transformation Steering Committee (TSC) meets twice monthly to review transformation programs and project activities, alignment and progress towards goals. The CHART program is a key component of the portfolio of transformation projects that the Transformation Steering Committee provides oversight to. • With purchase and implementation of the data visualization, "dashboard" tool through CHART funding, the data will be displayed with varying degrees of detail for the CHART operational group, the Transformation Analytic Group and the Transformation Steering Committee.
2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)?	• The Transformation Analytics Group (TAG) meets twice monthly to review data and oversee progress towards goals related to data capture and reporting. This group includes executives that are members of the Transformation Steering Committee and CHART leadership and operational (CHART) group members. • The CHART leadership and operational group meets at least monthly to review the programs activities and progress towards the program goals. Community partners are included in this group. • A subset of the CHART leadership and operational group meets on a more frequent basis with the CHART day to day operations team that performs a daily (M-F) review of patient level information that is shared with partnering providers in the CHART program.
3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)?	• The Transformation Steering Committee (TSC) meets twice monthly to review transformation programs and project activities, alignment and progress towards goals. The CHART program is a key component of the portfolio of transformation projects that the Transformation Steering Committee provides oversight to.
4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)?	• A subset of the CHART leadership and operational group meets on a more frequent basis with the CHART day to day operations team. • The CHART leadership and operational group meets at least monthly to review the programs activities and progress towards the program goals. Community partners are included in this group.
5. How often will your community partners review data (e.g., weekly, monthly)?	• The CHART leadership and operational group meets at least monthly to review the programs activities and progress towards the program goals. Community partners are included in this group.

Continuous improvement plan (2 of 2)

6. Which community partners will look at CHART data (specific providers and agencies)?	• Elder Services of the Merrimack Valley • Home Health VNA as needed • Preferred SNFs and Acute Rehabs as needed • Lahey Behavioral Health as needed
7. Will the quality committee of your board review CHART reporting (e.g., quarterly)?	The Transformation Steering team will report CHART initiatives, progress, and measures to the Trustee Quality Appraisal Committee periodically.
8. Who will collect measures and produce reporting (e.g., Data Analyst, PM, ID)?	The CHART Analytics team includes: Robin Hynds, Sr Director Care Integration & Transformation, Terry Sievers, Vice President of Quality & Patient Safety and CHART leadership and operational group members: Nicole Garabedian, Manager Integrated Care, Mark Walker, Clinical Nurse Leader, Maureen Hamel, Director of Quality Systems and Analytics, Derek Bourgoine, Population Health Analytics Manager, Danielle Owen, Quality Data Manager
9. How will you know when to make a change in your service model or operational tactics?	The LGH team is well-versed in conducting rapid-cycle improvement both within the hospital and with community partners. We understand and expect that the CHART process will be iterative with continuous improvement over time. During the STUDY phase, improvement strategies will be implemented and evaluated on a continuous basis.

Enabling Technologies plan (1 of 2)

Functionality	Users	Vendor	Cost
Patient Identification	Hospital Staff (Case Managers, Social Workers, & CNL)	- Paragon Enterprise Registration System* - Morrissey	$15,000
Patient Risk Leveling	Hospital Staff (Case Manager and Social Workers)	- Morrissey	$10,000
Real-time Alerts	Community Partner Staff (Elder Services)	- Morrissey - Care at Hand - MassHIway/Orion* - IBEX* - Paragon Connect*	$40,000 (Morrisey) $5,000 (Care at Hand)
Real-time Clinical Documentation Sharing	Hospital Staff (Case Managers, Social Workers, & CNL) and Community Partner Staff (Elder Services)	- Care at Hand - MassHIway/Orion* - Paragon Connect*	$50,000 (Care at Hand)
Bi-Directional Provisioned Access to Electronic Medical Record & Documentation Systems	Hospital Staff (Case Managers, Social Workers, & CNL) and Community Partner Staff (Elder Services & Lahey Behavioral Health)	- Care at Hand - McKesson Enterprise*	$5,000 (Care at Hand)

*Existing Lawrence General System, no additional cost to CHART

Enabling Technologies plan (2 of 2)

Functionality	User	Vendor	Cost
Data Visualization, Business Intelligence and Reporting Tools to transform data into actionable information	Transformation Analytics Group	- BOARD	$59,100
Data use agreement, integrity, and security for connection to the MassHIway	Hospital Staff (Case Managers, Social Workers, & CNL), TAG team, Community Partner Staff (Elder Services & Lahey Health Behavioral Services)	- Consulting engagement - Vendor will be determined later and as needed.	Total Cost = $20K CHART funded = $10,000
Consulting engagement/legal consultation regarding privacy, security, and data sharing with enabling technology	Lawrence General IT Department working on CHART enabling technology	- TBD	$20,000

Other essential investments

Other investments	Cost
Basic Necessities Funds: Funds for basic necessities for enrollees (transportation, medications, durable medical equipment, food, etc.)	$24,291
Patient Communication Aïds (estimate 100 phones): Provision of Trac Phones and minutes to facilitate communication between patient and clinical team	$3,000
Marketing Materials: Pamphlet for pt distribution describing the CHART program in English and Spanish	$2,000
Training: In-House Training for 4 new clinical staff and 27 current staff (Care Mgrs, SWS's), Advanced Training - 4 new clinical staff	$82,441
Quality Systems Director – pull and analyze data, and create reports	$171,699

Key dates (1 of 2)

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	10/1/15
Post jobs	Completed
New hires made	Completed
Execute contracts with service delivery partners	Completed
Initiatives support 50% of planned patient capacity	Completed
Initiatives support 100% of planned patient capacity	Completed
First test report of required measures	9/30/15
Trainings completed	See below
Motivational Interviewing	10/31/15
SBIRT	12/31/15
Care Transitions Education Project (CTEP)	9/30/17*
Community Health Education Course	06/1/16*
First patient seen	10/1/15
Enabling technology contracts executed with BOARD, Morrissey, and Care at Hand	Completed
Enabling technology testing initiated for BOARD	9/30/15
Enabling technology testing initiated for Morrissey	Completed
Enabling technology testing for Care at Hand	12/31/15

*Multiple course training programs; last training completed on noted date

Key dates (2 of 2)

Key milestone	Date
Enabling technology – BOARD go-live	10/1/15
Enabling technology – Morrissey go-live	Completed
Enabling technology – Care at Hand go-live	1/31/16
Enabling Technology – BOARD training (super users on 10/1 and ongoing training for selected others)	10/1/15
Enabling Technology – Morrissey training (SW staff trained on MCCM system and newest module of Continuum)	Completed
Enabling Technology – Care at Hand training for CHWs and SWs	1/31/16

Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Elder Services of the Merrimack Valley	280 Merrimack Street, Lawrence, MA 01843	www.esmv.org	Christine Tardiff	Director of Nursing and Community Service	603-560-0780	ctardiff@esmv.org
Morrisey	222 South Riverside Plaza Suite 1850 Chicago, IL 60606	http://salesweb.morriseyonline.com/wordpress/	Jeannie Schat	Sales Representative	978-855-3861	jschat@morriseyonline.com
Care at Hand	1425 9th Avenue San Francisco CA 94122	http://careathand.com/	Lori O'Connor	Chief Nursing Officer	978-807-6897	lori@careathand.com
BOARD	33 Broad Street, Suite 502 MA 02109 Boston	http://www.board.com/us/	Maureen Hamel	Quality Systems Director	978-683-4000 x2504	Maureen.hamel@lawrencegeneral.org
Contract for legal consultation regarding privacy, security, and data sharing in regards to enabling technology			TBD			